

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011794

FILED APR 6 1959 Registration District No. 317 Primary Registration District No. 590 STATE FILE NUMBER REGISTRAR'S No. 843

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1. PLACE OF DEATH a. COUNTY St. Louis Co.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ladue		c. CITY OR TOWN Ladue 4431	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 9450 Ladue		d. STREET ADDRESS (If outside, give location) 9450 Ladue	
3. NAME OF DECEASED (Type or print) Benjamin M. Vogel		4. DATE OF DEATH Month Day Year 3/28/59	
5. SEX male	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dentist		10b. KIND OF BUSINESS OR INDUSTRY DENTISTRY	11. BIRTHPLACE (City and state or country) St. Louis Mo
13a. FATHER'S NAME Guido Vogel		13b. MOTHER'S MAIDEN NAME Rachael Ebert	14. NAME OF HUSBAND OR WIFE Rosalie L. Vogel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES 1st World War		16. SOCIAL SECURITY NO. 487-44-6611	17. INFORMANT Address Rosalie Vogel, 9450 Ladue
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4201
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from 1949 to March 28, 1959 and last saw him alive on March 28, 1959. Death occurred at on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Julius Elson, M.D.	
22b. ADDRESS 607 N. Grand St. Louis		22c. DATE SIGNED 3/28/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) entombment	23b. DATE 3/30/59	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum	23d. LOCATION (City, town, or county) (State) No. 7800 St. Charles
24. FUNERAL DIRECTOR ADDRESS MAYER 4356 Lindell Blvd		25. DATE RECD. BY LOCAL REG. 3-29-59	
		26. REGISTRAR'S SIGNATURE John C. Murphy M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Stanley H. Wilson

Licensed Embalmer No. *4193*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.